INDEPENDENT VERIFICATION OF ASSETS AND LIABILITIES

State Form 51996 (R/7-05)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

INSTRUCTIONS:

Licensee:	*CPA:*
1. Complete sections I, II, and section III, F and G. *2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process.* *3. Forward the completed materials to a Certified Public Accountant.* *4. Upon return from the CPA, sign and date the certification statement in section V (Licensee) and include the entire set of documents with the completed application.*	*1. Complete sections III, A, B, C, D, and E by A. using an audit, review, or compilation completed within the preceding twelve months, or B. performing a financial compilation.* *2. Using agreed upon procedures; verify items in section IV, F.* *3. Sign and date the certification statement as indicated in Section IV (CPA).* *4. Attach the compilation and agreed upon procedures report to this form and return to the Licensee.*

Please Type or Print Legibly

SECTION I – TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership (*Anticipated date of Sale/Purchase/Lease:*_____)** ☐ **New Facility** ☐ **Other** _____

SECTION II - IDENTIFYING INFORMATION

A. Physical Location *(facility)*

Name of Facility:			
Street Address			
City		County	ZIP Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From *(mm/dd)*	To *(mm/dd):*

B. Licensee/Ownership Information

Licensee *(Operator(s) of the facility*) Same as Licensee on Application for License to Operate a Health Facility, Section B			
Street Address			P.O. Box
City	State	ZIP Code + 4	

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF_____

(date)

A. Current Assets:		**B. Current Liabilities:**	
Asset	**Amount** ***(rounded to nearest dollar)***	**Liability**	**Amount** ***(rounded to nearest dollar)***
Cash		Accounts Payable	
Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	
All Loans to Owners, Officers & Related Parties		**Total Current Liabilities**	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			

C. Working Capital: ***(Total Current Assets minus Total Current Liabilities)*** **$_____**

D. Total Liabilities: $_____ **E. Total Owner's Equity or Fund Balance: $ _____**

F. Lines of Credit *(List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary)***:**

Name of Institution or Lender	**Amount of Credit Available**
1.	$
2.	$
3.	$
4.	$

G. Number of Facility Beds: _____

Projected Monthly Revenue: $_____

Projected Monthly Operating Expenses: $_____

SECTION IV – CERTIFICATION STATEMENTS

Under penalty of perjury: I certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

Name of Authorized Person (*Typed*)	**Title/Position**
Signature of Authorized Person	**Date**

This is to confirm that I (we) have prepared a compilation of financial information which is the basis for the data indicated in sections A through E inclusive, and have verified the existence of the lines of credit listed in section F, pursuant to agreed upon procedures between myself (us) and the licensee(s) listed herein (see attached compilation and agreed upon procedures report).

Name of Certified Public Accountant representing the firm (*Typed*)	**Title/Position**	
Signature of Certified Public Accountant representing the firm	**License/Certification Number**	**Date**